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**“A Qualitative Investigation into Mitigating the  
Impact of Vicarious Trauma on Counsellors Dealing  
with Traumatic Client Material”.**

**Pamela Susan Collins.**

**Dissertation submitted to the University of Chester  
for the Degree of Master of Arts (Counselling  
Studies) in part fulfilment of the Modular Programme  
in Counselling Studies, November 2010.**

## **Abstract.**

This qualitative research study investigates mitigating the impact of vicarious trauma on counsellors who have experience of working with traumatic client material. The data was gathered from six participants, using semi-structured interviews and analysed by the constant comparative method, an adapted form of grounded theory. Analysis of the data established that all participants had mitigated against the effects of vicarious trauma by adopting their own personal strategies to limit the effects of working with traumatic client material. A major theme to emerge was the ineffectiveness of supervision to meet the expectations of most participants. This challenges relevant research in this area. Other strategies identified were talking to others, writing and physical activity. All participants commented on how they could make a difference and this seemed to be a mitigating factor in itself.

## **Declaration.**

The work is original and has not been submitted previously in support of any qualification or course.

Signed .....

Pamela Susan Collins.

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## **Introduction.**

Whilst studying an abuse module I was influenced by the work on vicarious trauma by Pearlman & Saakvitne (1995). This was the first time that I had heard of vicarious trauma, and the impact it could have on counsellors dealing with traumatic client material, despite being qualified to diploma level. Pearlman and Saakvitne describe “vicarious traumatisation” as “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with clients’ trauma material” (p.279).

I began to reflect on why I had not thought more about the effects that traumatic client material may have on me. The concept seemed obvious as I have experience of how stories heard from friends, colleagues and peers have affected my own belief system vicariously. For twenty seven years I have been a driving instructor. Being on a one to one with students, in a space that provided isolation from their own world, confidentiality and someone who took the time to listen, enabled them to share their stories with me. Many of these, however, were extremely harrowing stories of sexual abuse, domestic violence, bullying, stalking etc.

Over the years my own frame of reference was distorted in such a way that I lost faith in humanity. Before undergoing counsellor training I was already aware of this and how I had been hugely affected, in a negative way. I changed from a naive, trusting and caring person into a suspicious, paranoid and mistrusting being. These examples, it could be argued, are a clear case of myself being affected by vicarious traumatisation (Herman, 2001).

I have, therefore, had personal experience of how hearing shocking, frightening and heart rendering stories can bite at the essence of the self and transform every aspect of your life. Ely, Anzul, Friedman, Garner and McCormack Steinmetz (1991) point out that our life experiences are what draw us to certain topics of research. My enthusiasm, quest for knowledge and desire to ensure I limit the effects of vicarious traumatisation on myself, led me to review the available literature (See Chapter 1).

I then began to discuss vicarious trauma with my counselling colleagues. Some of these colleagues appeared to know about the concept of vicarious trauma (although they may not have explicitly labelled it as such), however, did not believe that they were affected by it (Herbert & Wetmore, 2008). Further discussion between them and myself uncovered potential indicators that vicarious trauma may exist within them. These counsellors were either surprised by their discovery that they had in fact been affected by vicarious trauma or refused to believe this may be the case and attributed other reasons for the changes within themselves. Saakvitne and Pearlman (1996), argue that, awareness and acceptance of vicarious trauma are the first steps to mitigating against it (Bober, Regehr & Zhou, 2006; Rothschild, 2006).

Fortunately a few years ago, I followed a path into counselling, where I have managed to re-establish more balanced beliefs, values and world-view. Because of this personal experience, however, it made sense to me that being exposed to clients' traumatic narratives could affect therapists' beliefs, values and life philosophy (Chouliara, Hutchinson & Karatzias, 2009; McCann & Pearlman, 1990). It was relatively easy for me to link and understand how counsellors may be affected by vicarious traumatisation and the issues this may raise. My colleagues' naivety on the impact of vicarious trauma raised concerns that counsellors may not be aware of

vicarious trauma, or may not have knowledge of its existence. It also raised questions in my process that, if they do, do they know how to alleviate it (McCann & Pearlman, 1990)?

I became more focused on the steps counsellors, dealing with traumatic client material, may take to mitigate against the effects of vicarious trauma, what they may have found alleviates vicarious trauma, and what does not? Taking into account Pearlman and Saakvitne's (1995) statement, that vicarious trauma is inevitable, then the importance of how to mitigate the effects becomes vital to the counselling profession.

I have, therefore, undertaken a small scale qualitative research study investigating the impact that vicarious trauma has on counsellors dealing with traumatic client material. I interviewed six participants from the counselling profession who worked with clients who divulged traumatic material. I used a phenomenological approach, with purposive sampling, and data collection via semi-structured interviews (between 30-60 minutes). A constant comparative method of data analysis, adapted from grounded theory, was used and the results are outlined in chapter 3.

I believe this research will be of value to the counselling profession (Cooper, 2008; Timulak, 2008) as I believe there is a need for enlightenment around this subject. To date the British research conducted in this area has not focussed sufficiently on mitigating the impact of vicarious trauma and how this might affect counsellors' private and professional lives (Chouliara et al., 2009; Dunkley & Whelan, 2006a). I believe the knowledge gained from this research will benefit in the education, training and supervision of counsellors, as well as in the area of counsellor self-care.

Throughout this dissertation, when using the terms “counsellor” and “therapist”, I will be referring to counsellors and therapists who are working with traumatic client material. The following chapter will outline the research covering the subject area of vicarious trauma in greater depth.

## **Chapter 1.**

### **Literature Review.**

#### **1.1 Literature Search Rationale.**

I initially did a brief literature search and having designed the research study I then undertook a more thorough and exhaustive one. I sourced several books from my own library, colleagues, Google books and the University of Chester library. Pearlman and Saakvitne's (1995) work seems to have been the foundation of various pieces of research over the last fifteen years. To date there are limited books on vicarious trauma. I focused, therefore, my attention on tracking down and reading various research journals, magazine articles and dissertations. I achieved this by searching my personal collection, visiting University of Chester's journal library, and through colleagues. I extensively searched electronic data bases, PsycINFO, PsycARTICLES, PsycBOOKS and Psychology and Behavioural Sciences. I further searched using Google Scholar data base (see appendix 10).

My search terms were: "vicarious trauma", "vt", "vicarious traumatisaion", "vicarious traumatization", "counsellor", "counselor", "therapist". All these combinations of (English and American) words were also used with the terms "impact", "mitigating", "limiting", "reducing", "empathic", "empathic engagement", "supervision", "trauma supervision" and "trauma therapy supervision".

## 1.2: Overview of the literature explored.

The literature focused on a number of areas relating to vicarious trauma. A number of articles looked at the after effects of counselling clients with a history of sexual abuse. Other research touched on attachment styles, the use of supervision and the impact of vicarious trauma on counsellors; however, a significant amount explored coping strategies, mitigating circumstances and how to achieve counsellor well-being. It was vital to gain knowledge in what, when, how and why vicarious trauma impacts on counsellors dealing with traumatic client material. Without this, there would not be a base to understand how to mitigate against the effects of vicarious trauma.

In order to outline this research I have divided the literature into subsections. I will initially define vicarious trauma and explain what vicarious trauma is not. I will then go on to discuss the impact of vicarious trauma on the counsellor's frame of reference (including, identity, world view and spirituality). I will then look at the symptoms of vicarious trauma. Whilst this research is primarily focused on mitigating the effects of vicarious trauma, I feel it is important to have some knowledge of these other areas. Without which, we cannot move on to understanding mitigation. I will then move on to the literature related to the mitigating factors of vicarious trauma.

## 1.3: Defining vicarious trauma.

Although McCann and Pearlman (1990) coined the term vicarious trauma (Rasmussen, 2005; Pearlman & Mac Ian, 1995), for the purposes of this research paper I will use Pearlman and Saakvitne's (1995) definition. "Vicarious traumatization

is a process through which the therapist's inner experience is negatively transformed through empathic engagement with clients' trauma material" (p.279). They argue that, it is this empathic engagement that amplifies the intensity of vicarious trauma. As empathy is a major process used by the counselling profession, this stands them apart from other professionals in the field of dealing with people's traumatic experiences (Dunkley & Whelan, 2006a; Rothschild, 2006). This negative effect pervades every aspect of the counsellor's frame of reference leaving them vulnerable, isolated and disenchanted with the world they live in (Schauben & Frazier, 1995). It needs to be acknowledged, however, that there are certain theoretical orientations within the counselling profession that may not have the same depth of empathic engagement as others (i.e. cognitive behaviour therapy).

Originally I found differing opinions defining exactly what vicarious trauma is or is not. There is often confusion and misunderstanding with other terms i.e. counter transference, burnout, compassion fatigue and secondary post traumatic stress. For clarification none of these are vicarious trauma, however, they do share some of the same characteristics. The defining difference of vicarious traumatization is that it "emphasizes the role of meaning and adaptation, rather than symptoms" (Pearlman & Saakvitne, 1995, p.p. 280-281). For further discussion see: Harrison and Westwood (2009), Canfield (2005), Salston and Figley (2003), Jenkins and Baird (2002a), Saakvitne, (2002), Pearlman and Mac Ian (1995) and McCann and Pearlman (1990).

#### 1.4: The impact of vicarious trauma on the counsellor's frame of reference (including, identity, world view and spirituality).

McCann and Pearlman (1990) posit that exposure to traumatic client material will over time, alter or disrupt the counsellor's cognitive schemas which create their reality. Saakvitne (2002) further argues that the therapist's self is disrupted in such a negative way that it affects their "self capacity, frame of reference, realms of perception, memory, basic beliefs and psychological needs" (p.447). Five essential areas are highlighted. These are: safety, trust, esteem, control and intimacy (Pearlman & Saakvitne, 1995; Trippany, White Kress & Wilcoxon, 2004).

According to Pearlman and Saakvitne (1995) vicarious trauma is distinct in the way it affects therapists where the inner-self is negatively transformed by the traumatic material they receive through empathic engagement with their clients (Chouliara, et al., 2009; Dunkley & Whelan, 2006a; VanDeusen, 2006). Trippany et al. (2004) support this view arguing that empathic engagement with trauma clients is thought to be the root of vicarious trauma. Sexton (1999) highlights the value of empathic engagement with trauma clients in psychotherapy, however, points out this may in fact make the counsellor more vulnerable to the effects of vicarious trauma.

It has also been argued that vicarious trauma has no boundaries, pervading each aspect of the therapist's life, family, social, professional and spiritual (Adams & Riggs, 2008). McCann and Pearlman (1990) state "It is our belief that all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on the therapist's feelings, relationships, and life" (p.136).



McCann and Pearlman (1990) state that “the need to develop a meaningful frame of reference for experience is a fundamental human need” (p.141). The most damaging effect of vicarious trauma is said to be the altering and transforming of the counsellor’s identity, world view and spirituality, as these are the foundation on which they view, experience and make sense of their world (Baird & Kracen, 2006; Eidelson, D’Alessio & Eidelson, 2003).

Hearing the client’s traumatic material, therefore, may lead to counsellors challenging their basic beliefs about their role in life, self-worth and identity. Neumann and Gamble (1995) suggest that they begin to view their world through a “trauma lens” (p.334). This may create a feeling of numbness, disconnection and withdrawal from others (Dunkley & Whelan, 2006a). Counsellors may react to strong distressing emotions by dissociating from their bodily senses into their head; thinking rather than feeling. This can be a defence in a counselling session or protection outside (Rothschild, 2006). Professionally the counsellor may question why they are doing this work and how competent they are to do it (Herbert & Wetmore, 2008; Herman, 2001).

Listening to trauma stories repeatedly, challenges how the counsellor perceives the world in which they live, their philosophy, values and morals of how they view others. The loss of their old world can be seen as bereavement, possibly leaving the counsellor sad, angry and bewildered. Trust is lost in all walks of life, questioning safety of others, becoming suspicious of people they would have trusted and cynicism at society (Canfield, 2005; Neumann & Gamble, 1995; McCann & Pearlman, 1990). It is quite common, for example, for counsellors who have been

exposed to client's stories of sexual abuse, to prohibit their children from staying overnight at friends houses for fear of sexual abuse.

The spiritual side of the counsellor does not escape the grip of vicarious trauma. It can eat away at hope, creativity and the ability to love, leaving counsellors in despair, pessimistic, disconnected and isolated (Herman, 2001). Brady, Guy, Poelstra and Fletcher Brokaw (1999) posit that spirituality is affected more than any other domain by listening to traumatic stories and is a danger to their well-being. Canfield (2005) suggests that trauma clients put a greater need on counsellors, pushing them to become too involved professionally, instead of knowing their limits and taking care of themselves. Etherington (2000) argues that a loss in faith and humanity, causes counsellors to challenge where their caring side has disappeared to. This impacts their spiritual core and purpose in life (Canfield, 2005). Meyer and Ponton (2006) highlight that the loss of meaning in their lives, leads to emptiness and a loss of their spirit.

### 1.5: Symptoms of vicarious trauma.

As vicarious trauma is "unique" to each therapist, the symptoms, which are an expression of vicarious trauma, are many and varied (Herbert & Wetmore 2008; Marmaras, Lee, Siegal & Reich, 2003). Adams and Riggs (2008) note that these symptoms are similar to post traumatic stress symptoms, for example, stress, depression, intrusive thoughts/feelings, sadness, avoidance. According to Pearlman and Saakvitne (1995) the intrusion of "sadistic imagery into the therapist's own inner life" (p.293) is a defining symptom of vicarious trauma. Neumann and Gamble (1995) support this, stating that "flashing" (p.344) of disturbing imagery occurs outside of

counselling sessions, causing immense distress for counsellors. Dunkley and Whelan (2006a) point out that this imagery, re-experiencing the client's graphic traumas, nightmares and intrusive thoughts all contribute to the counsellor being in a persistent state of arousal. This creates ongoing anxiety, anger and distress.

It is not unusual for counsellors working with trauma to also find themselves suffering somatic symptoms, such as nausea, headaches, physical numbness, sleeplessness (Adams & Riggs, 2008; Neumann & Gamble, 1995). Rothschild (2006) suggests that counsellors may also experience physical sensations matching those of their client's. Sommer (2008) adds that they may also avoid situations, places and activities that their clients link to their traumas. They may also experience dreams linked to their client's traumatic experiences. Herbert and Wetmore (2008) voice concerns at how vicarious trauma can leave counsellors drained of energy, exhausted and lacking in motivation. These symptoms are frequently not linked to their origins, and I would argue, this leaves counsellors even more vulnerable to the effects of vicarious trauma.

Meyer and Ponton (2006) highlight that symptoms of vicarious trauma can also manifest themselves in professional terms for counsellors. Boundaries may become blurred, agreeing limits becomes difficult, therapy ends early and administration tasks become chaotic. Herbert and Wetmore (2008) argue that therapists may begin to question their career choice. Symptoms that manifest personally can include intrusive imagery, loss of trust in others, inappropriate anger, insecurity, cynicism, relational difficulties, emotional and/or physical withdrawal from society (Harrison & Westwood, 2009; Herman, 2001).

## 1.6: The mitigating factors of vicarious trauma.

In view of the impact vicarious trauma has on counsellors dealing with traumatic material, Pearlman and Saakvitne (1995) draw attention to how the therapeutic relationship may be harmed, “as vicarious traumatisation affects the self of the therapist, it will emerge in the therapeutic relationship directly and through counter-transference” (p.294). This is supported by Rasmussen (2005) and Herman (2001). Herbert and Wetmore (2008) go further stating that, clients will not receive the best service when the counsellor is emotionally drained, burnt out or closed down to their clients’ needs.

Taking into account the damaging effect vicarious trauma has on the counsellor’s relationships, both professional and personal (Meyer & Pontin, 2006) it can be argued that there is a need to be able to mitigate the effects of vicarious traumatisation. Saakvitne (2002) suggests that the best protection from vicarious trauma is to balance work, rest and play (Chouliara et al., 2009; Hafkenscheid, 2005). She goes on to posit three areas central to mitigating the effects of vicarious trauma. Awareness: understanding our limits, needs, emotions and ability to accept the presence of vicarious trauma within themselves. I would argue that awareness is the first step in mitigating vicarious trauma. Balance: the ability to be able to balance internal and external life. Connection: Keeping connected to ourselves, others and the wider world is vital in order to fight and stave off the isolation felt by sufferers of vicarious trauma.

Sexton (1999) supports this theory adding that an important part of counsellor’s self-care is being responsible in attending regular supervision. Herbert and Wetmore

(2008) argue that if the counsellor fails in their self-care and becomes unfit to practice due to exhaustion, they will not give a good service to the client and will be of no benefit to them at all. They further point out, that even though vicarious trauma cannot be prevented and is seen as “an occupational hazard” (Canfield, 2005, p.88) counsellors have a responsibility to mitigate against it as much as possible.

Bober et al. (2006) state that professional, social and emotional support are also ways to alleviate the impact of vicarious traumatisation (Dunkley & Whelan, 2006b; Sexton, 1999). Harrison and Westwood (2009) agree. Trippany et al. (2004) highlight the importance of having peer support from colleagues. They posit that it is a chance to share experiences, gain reassurance that they are not alone in the way they think, feel and express themselves. Knight (2004) believes that normalising what the counsellor is experiencing can also be a strong mitigator to vicarious trauma. This enables them to re-establish their view on what is happening to them.

This type of support network enables counsellors to gain knowledge, share coping strategies and to reconnect with others once more. Clemans (2004) supports this view adding that education in this area is needed too. Etherington (2000) re-enforces the view that counsellors cannot do this work alone, they need peer support. This gives a chance to express their thoughts, feelings and emotions and gives encouragement to bring material out into the open which is causing them to become isolated, both personally and professionally. This process is similar to clinical supervision. Sommer and Cox (2005) add that balancing or reducing their caseloads of trauma clients or going to weekly forums to gain peer support, may help to alleviate the counsellor’s vicarious trauma (Hafkenscheid, 2005; Cunningham, 2004).

Sommer (2008) suggests that supervision is important and should be actively used to combat vicarious trauma (Westbrook, Kennerley & Kirk, 2008; Dunkley & Whelan, 2006a; Marmaras et al., 2003). Pearlman and Saakvitne (1995) state that trauma therapy should not, and more importantly, cannot be done by oneself, due to the negative effects vicarious trauma has on the counsellor. They suggest that receiving specific, trauma therapy clinical supervision, may keep the counsellor focused, boundaried and grounded. They further recommend trauma counsellors should ideally receive this once a week if possible.

Pearlman and Saakvitne (1995) do not see general clinical supervision as being sufficient for counsellors dealing with traumatic client material. They, therefore, recommend four parts to be incorporated into general clinical supervision over time. These four areas are: A “solid theoretical grounding” i.e. theoretical understanding of trauma therapy, child development and theory of the psychological responses to interpersonal violence. A “relational focus” viewing the conscious and unconscious components of the therapeutic relationship and therapy direction. “Attention to counter-transference and parallel process” and finally “education” about vicarious trauma and how it may affect the counsellor dealing with traumatic material (p.360).

Meyer and Pontin (2006) also point out the importance of receiving supervision from “trauma-therapy supervisors” (p.198) and see this as an essential service to keep the counsellor healthy. Etherington (2000) argues that clinical supervision gives counsellors a safe place to examine their client counter-transference responses, express their feelings and gain understanding of what may be happening to themselves both personally and professionally. Supervision, however, will only alleviate vicarious trauma symptoms if counsellors are prepared to share their

negative feelings, thoughts and actions. Otherwise this lack of care for themselves may lead to stress, tiredness and a lack of connection with their client.

Research does show that counsellors are affected by stigma and, therefore, may not be able to show their supervisor that they have made mistakes, feel inadequate to deal with troubling client material, or show shame (Sommer & Cox, 2005). This may all add to the effect of vicarious trauma on the counsellor and create a barrier to empathic connection with their client, thus harming the therapeutic relationship (Herbert & Wetmore, 2008). Harrison and Westwood (2009) believe that clinical supervision can act as an early protection to prevent burnout and damage to the therapist. Wheeler (2007) supports this view. Herbert and Wetmore (2008), however, contend, as above, that all this may not help if the counsellor is affected by a stigma that prevents them admitting that they are affected by what their clients disclose.

One way to reduce the effects of stigma may be to educate counsellors about vicarious trauma. Marmaras et al. (2003) suggests that educating counsellors in the impact of vicarious trauma may create an awareness that will equip them to better deal with the consequences of vicarious trauma (Phoenix, 2007; VanDeusen, 2006). Bringing the topic of vicarious trauma to the foreground in counsellor's minds by carrying out and publishing more research in this area may help. Ensuring the training of new counsellors and supervisors includes a thorough introduction to the effects of vicarious trauma and how to mitigate against it may also be useful. If eminent counsellors publically acknowledge the effects of vicarious trauma on themselves this may go some way to breaking down the stigma attached to being affected by vicarious trauma. Harrison and Westwood (2009) believe there is an

ethical obligation for organisations, trainers and educators to warn new counsellors about the risk of vicarious trauma along with preventative practices.

Rothschild (2006) believes, however, that a counsellor may be able to do more during the counselling session to mitigate the effects of vicarious trauma. She posits that for counsellors to look after their physical and emotional well-being, they must find ways “to balance her empathic engagement, regulate her ANS (autonomic nervous system) arousal, and maintain her ability to think clearly” (p.3). Rothschild has numerous strategies and policies to aid in this during counselling sessions. For example, trying not to imagine the traumatic scene visually, lowering the empathic engagement with the client by breaking eye contact regularly, being self and body aware enough to change their breathing pattern to a more relaxed state, changing facial and bodily postures to disengage from the client trauma, pain and torment and even consider wearing thicker cloths to act as a shield. Terr (1985) supports this, acknowledging that visualisations can compound vicarious trauma, self-awareness decreases vicarious trauma and that body awareness is the key to lowering the effect of vicarious trauma.

Sexton’s (1999) concern is that vicarious trauma impacts on the counsellors’ spiritual self, affecting their sense of meaning, hope and connection to the world leaving them faithless (Canfield, 2005). This is not, however, the whole story. In order to address this negative effect, counsellors need to gain a sense of humour, a realistic sense of optimism and hopefulness when dealing with traumatic client material. Brady et al. (1999) believe that it is in the spiritual domain that counsellors are affected the most by trauma work. They go on to state, however, that the more exposure counsellors have to traumatic material, the more spiritually satisfying their lives.



Pearlman and Saakvitne (1995) explain this process, as the counsellor's awareness of their client's strength, in overcoming their trauma in order to survive. Counsellors in witnessing this, can create a positive growth in their belief in clients ability to heal, forgive and move on, and in turn they may gain a better spiritual well-being (Rasmussen, 2005; Schauben & Frazier, 1995). Brady et al. (1999) consider this stronger connection with their spiritual self encourages counsellors to work more with traumatic client material, enjoying the spiritual challenge this work poses for them. The mitigating strategies previously discussed would be considered to be healthy ones, however, Phoenix (2007) brought to my attention that not all mitigating strategies are healthy ones, such as alcohol, substance misuse or food as a coping strategy to mitigate against the effects of vicarious trauma.

### 1.7: Summary of the research discussed.

This literature search has identified key areas to consider when considering what strategies may mitigate the effects of vicarious trauma. Pearlman has led the way with her work through the 1990's with McCann, Saakvitne and Mac Ian. Their work has brought the topic of vicarious trauma into the counselling arena, gaining recognition of its damaging effects on counsellors, both personally and professionally. Their work has been the foundation for many research studies and a substantial body of research has grown out of their original research.

I have gone on to incorporate other literature discussing the impact vicarious trauma has on a counsellor's frame of reference, as well as what the many and varied symptoms may be. I have looked at what might mitigate the effects of vicarious trauma and balancing work, rest and play is a strong view taken by leading

researchers (Sexton, 1999; Pearlman & Saakvitne, 1995). Awareness of vicarious trauma was also a major mitigating factor. Seeking professional support from supervisors, line managers and peers may be of value, however, personal support is also encouraged from partners, family and friends (Schauben & Frazier, 1995). Simply talking appears to be an effective mitigator to vicarious trauma. Lowering case loads, mixing trauma clients with less demanding cases and even working fewer hours may also help to alleviate vicarious trauma (Harrison & Westwood, 2009). Seeking a specialist trauma therapy supervisor to receive specific education, a deeper understanding of trauma therapy and support, is also advocated (Etherington, 2000). A further area to show a mitigating effect is personal growth through the successes of therapy with clients who have experienced trauma.

The following chapter will take the reader through the process this research has taken. It will discuss and outline my audit trail, procedures followed and underlying methodology.

## **Chapter 2.**

### **Methodology.**

#### **2.1: Research Design.**

When designing this research study I found formulating the research title was harder than I had expected. Bryman (2007) argues that this is the hardest part in the research design. I originally wanted to investigate the awareness counsellors had of vicarious trauma. At a tutorial, however, it was brought to my attention that this may have ethical considerations. This is due to the possibility of participants uncovering new knowledge that may have a harmful effect on them (BACP, 2009; Potter, 2002). I, therefore, started again, looking at what it is about vicarious trauma that created such an interest for me. This seemed to suit my own process; McLeod (1999) and Willig (2008) highlight “good qualitative research questions tend to be process-oriented” (p.20). Ely et al. (1991) argues this is an evolving process and the researcher’s original question is rarely used.

Initially I had assumed that I would do quantitative research. My rationale for this was that I had a natural leaning towards scientific models, enjoyed statistics, preferred to see data pictorially in graph form or pie charts, and wanted to produce a large scale study that may have supported the research in my chosen area (Lebow, 2006; Ponterotto, 2005). Whilst studying this paradigm in depth during this module, I became aware of the philosophy behind it, which challenged my personal and professional development and my view wavered.

Quantitative research is referred to as the old paradigm. This was and still is seen as the established scientific, experimental, measurable, statistical, observable and reliable way to quantify “subjects” into defined categories (Denscombe, 2003; McLeod, 1999). McLeod (2003) states, that the old paradigm takes the philosophical position that “regards knowledge as unitary, and, therefore, attainable through a standardised set of scientific procedures” (p.71). Madill and Gough (2008) argue that “dissatisfaction with cognitive—experimental psychology in the 1960s and 1970s” (p.254) led to the emergence of qualitative research, which became more widespread through the 1980-90’s (Parker, 1989). Elliott, Fischer and Rennie (1999) argue that there has been a “dramatic increase” in this area (p.215).

As time went on, however, my own process began to lead me away from quantitative theory (Ponterotto, 2005; Maykut & Morehouse, 1994). I began to see it as running contrary to how I see my own client-work within the counselling arena and the types of lived experience I was interested in exploring with participants. This showed me that quantitative research no longer fit easily within my belief system. It also fit more congruently with my recent adoption of social constructionism into my professional and personal life. This I believe sits more comfortably with qualitative theory, as it is a characteristic of it (McLeod, 2003; Bannister, Burman, Parker, Taylor & Tindall, 1994; Lincoln & Guba, 1985).

Qualitative researchers see participants as people as opposed to subjects. McLeod (2003) points out that qualitative philosophy sees each participant as being unique, holistic, and contextual and that reality is socially constructed (Denzin & Lincoln, 2003). “Qualitative research is based on a phenomenological position, while quantitative research is based on a positivist position” (Maykut & Morehouse, 1994,

p.3; Banister et al., 1994). The underlying philosophy of the phenomenological position aims to understand the experiences, world view and inner-self of the participant's world from their own perspective. The researcher attempts to become completely immersed in the participants' narratives related to what is being researched (Loewenthal, 2007). This helps them to fully embrace and understand the true essence of the participant's world (Spinelli, 2005).

Alongside this I had been pondering the nature of vicarious traumatising. If it is unique to each counsellor it would not lend itself to standardisation, nor would it be observable as the emotional effect brought about through vicarious trauma (Madill, 2007; Spinelli, 2005; Marmaras et al., 2003). McLeod's (1999) view considers qualitative research "a process of systematic inquiry into the meanings which people employ to make sense of and guide their actions" (p.117). With this in mind, therefore, I believe the only research paradigm that would do justice to this subject area is qualitative research.

## 2.2: Ethical Considerations.

Ethical approval was sought from the University of Chester at the outset of this research study and a research supervisor was assigned. During the research process I have adhered to the British Association for Counselling and Psychotherapy ethical guidelines for research (Bond, 2004a) believing that the safety of the participants is paramount (non-maleficence).

Safety of client and informed consent. Due to the nature of this research, I felt that the material to be discussed may evoke strong emotions and thoughts. Whilst giving

respect to the participants' autonomy, the selection process has ensured that the participants had access to, and were willing to use, personal therapy. All participants were also receiving clinical supervision. This ensured participants had access to support in the event of difficult material being evoked. It further allowed me to remain purely as researcher and not enter a dual relationship, as counsellor, with the participants. For the same reasons I also had access to personal therapy and research supervision.

I ensured that all participants had been fully informed about the research as far as possible, both verbally and in writing. Before the interviews began I checked with the participants that they understood the implications of the study and I gave them the chance to clarify anything they were unsure of. All participants gave informed consent in writing (Christians, 2003; Banister et al., 1994) (see Appendix 2, 4, & 5).

Confidentiality is also an ethical consideration. I have attempted to work with integrity and I have explained confidentiality and the limitations in relation to this study. I have ensured that there is no way of identifying the participant from the transcript and all identifying material has been removed. Only I know the codes used for data collection. I alone have transcribed the tapes; however, they will be available to those involved in supervising and assessing this dissertation, if required. The participants are aware that this research will be entering the public domain (Flick, 2006; McLeod, 2003). I have continued to respect the participants' autonomy by ensuring that each participant understands that they have the right to withdraw from the study at any point, up until the final deadline (Le Voi, 2002).

### 2.3: Reliability, Validity, Trustworthiness.

Trustworthiness in research is considered an important concept because it determines whether the research undertaken is believable (Maykut & Morehouse, 1994). This is easier to demonstrate in quantitative research where a large number of statistical tests are available to validate the data. In qualitative research, however, where the data is more subjective and open to different interpretations, a different approach has to be undertaken (McLeod, 2003). Maykut and Morehouse (1994) suggest monitoring the research process to ensure trustworthiness with regard to four areas: multiple methods of data collection, building an audit trail, working with a research team and member checks. These are discussed below.

I have not had the advantage of working as part of a research team and being a lone researcher in qualitative research brings a responsibility for the researcher to work with integrity. Haverkamp (2005) asserts that there is a principle of fidelity to be honoured. To address this concern I have attempted to gain sufficient depth of knowledge in research design, delivery and ethical awareness. I have also worked with a research supervisor.

I have also developed skills to enable me to interpret, understand and accurately present the participants' material (Banister et al., 1994). Feeling that I have an ethical obligation to the participants and this qualitative research study, to accurately represent the participants' lived experiences, I have attempted to do this wherever possible in their own words, letting them tell their own story.

I feel that my knowledge and interest of vicarious trauma (and my own experience of vicarious traumatising discussed earlier) had the potential to influence me during this research, and Madill and Gough (2008) question whether the researcher can actually remain unbiased. Being aware of this, however, has allowed my supervisor and myself to monitor this constantly (Etherington, 2004) thus maintaining researcher integrity. I have endeavoured to keep my own bias to a minimum (Banister et al, 1994) and in an attempt to remain transparent (Bond, 2004) I have used my research supervisor and peer group to reflect any bias, flaws and/or any transferential issues that may have arisen (Willig, 2008; Lincoln & Guba, 1985). Designing the research questions to eliminate all bias was difficult and took several drafts. It became apparent that if I had any bias in these questions then it may affect the whole validity of this study and I may not be accurately representing the participants' experiences (Denscombe, 2003; Oppenheim, 1992).

Throughout this research I have kept a research journal, which I have used to record my thoughts, discoveries and ideas. Etherington (2004) supports this process believing it to be an important part of qualitative research (Banister et al., 1994). This is part of my audit trail, and is an important record to show the process that I have gone through whilst undertaking this research project (Flick, 2006; Lincoln & Guba, 1985).

All participants have been offered a copy of their tape and transcript to check authenticity, accuracy and that they are still in agreement with partaking in this research (Bond, 2004b).



## 2.4: Sample: Selection criteria.

When choosing a research sample I considered the use of probability or non probability samples (Denscombe, 2003). I rejected probability sampling, i.e. random or systematic sampling, feeling that six participants were too few to gain a true cross section of the counselling population (McLeod, 1999). The decision to use non-probability sampling then led me to choose, a purposive sample for this research, as supported by Maykut and Morehouse (1994). Selecting the most relevant participants has yielded valuable data, accepting that each participant is an individual with unique thoughts, beliefs and values, hence, cannot be generalised (Denzin & Lincoln, 2003). A purposive sample gave me the opportunity to select participants most relevant for my research topic, after using a mini questionnaire designed to highlight selected criteria (Appendix 3). Only counsellors with two years post qualification, dealing with traumatic client material and who felt they had changed as a result of this work, were selected. This process then enabled me to gain a maximum variation sample, for example, participant's age, gender, race etc (Maykut & Morehouse, 1994).

Willig (2008) argues that it is not possible for a qualitative research study to use a representative sample, as there are too few participants; however, this is not what this research sets out to do. Other types of sampling, for example, theoretical or snowballing were considered, however, were felt not suitable for my proposed timetable.

I interviewed only participants who were counsellors working with traumatic client material, with a minimum of two years post qualification experience. The rationale for this was that vicarious trauma is argued to affect counsellors more than other

professions (i.e. firemen, paramedics, nurses etc.) due to the empathic engagement entered into during counselling sessions. It was necessary to set a minimum time, post qualification, due to the nature of vicarious trauma affecting counsellors over a period of time, rather than from a single incident (Salston & Figley, 2003; Pearlman & Mac Ian, 1995).

It was also a requirement for participants to be in clinical supervision in line with the BACP “Ethical Framework for Good Practice in Counselling & Psychotherapy” (BACP, 2009) and to have access to a personal therapist for two reasons. Firstly, it ensured that participants were not put at any risk of being left with troubling material, which may have been provoked during and after the interviews had taken place. Whilst this was not my intention, it is always a possibility when working with participant’s own material (Bond, 2004b). Secondly, it left me free to be an interviewer not a counsellor, which also allows me to reduce bias (Madill & Gough, 2008).

## 2.5: Sample: Participants selected.

To attain my sample, I advertised through the British Association for Counselling and Psychotherapy (BACP), local journals and magazines. I arranged for flyers (Appendix 1) to be sent to counselling organisations (by post, hand or electronically). I contacted colleagues who have access to other counsellors and sent them my research advert to distribute. I also mail shot Universities and Colleges, who have post qualification counsellors studying further courses. I did not use my own organisations to canvass for potential participants, as I felt, that a dual relationship could have affected the data collected (Bond, 2004a).

When potential participants contacted me, I sent out more detailed information about the study, myself (Appendix 2) and a mini questionnaire (Appendix 3) which took no more than ten minutes to fill in. The questionnaire enabled me to define the parameters that I was looking for in potential participants.

Six participants took part in this research study. They consisted of four women and two men. Five were white British, one was Asian. Five were heterosexual, one was gay. All participants were able-bodied. Their age ranged between forty to sixty years of age. All participants were married, four had children. None of the participants lived alone. Four participants were working full-time, two were working part-time. Four participants were currently working in secondary care and two were in primary care at the time of the study. All participants had worked and were currently working with traumatic client material. All participants stated they were person-centred, integrative or humanistic. Where participants were not purely person-centred, I clarified with them that they worked from a person-centred base and thus engaged empathically with their clients.

Six other counsellors expressed an interest in this study; however, after sending them more detailed information (Appendix 1, 2, & 3) they withdrew stating they were not affected by their work with traumatic client material. This was the case for several potential participants, even when they reported symptoms of vicarious trauma during telephone conversations or written correspondence with myself.

## 2.6: Data collection.

Initially I had intended to send out questionnaires, containing open questions, to collect the research data. When I considered how difficult it would be to design the questions, so that each participant interpreted them similarly, keep participants focused on the questions, time factors, low response rates, inaccessibility for visual impairments, dyslexia, etc. (Denscombe, 2003; McLeod, 2003; Oppenheim, 1992), I decided against this. Upon further reflection I also realised that this method of data collection may not gain the rich data that the research study required (Leech & Onwuegbuzie, 2007; Maykut & Moorehouse, 1994).

I, therefore, decided to interview participants directly believing this to be the best way of understanding the participants' "experience in context" (Maykut & Moorehouse, p.45). I have, however, noted Gerson and Horowitch's caution that this would require "substantial forethought and advance planning" (2002, p.p.204). I then considered which type of interview would best suit this research study and myself. I felt that unstructured interviews may give me material that was off topic, unstructured and difficult to analyse. A structured interview, however, may not give the participants the space to explore their own experiences at their own pace (Flick, 2006; Denscombe, 2003; McLeod, 1999). I decided, therefore, to use semi-structured interviews, believing this gave me the chance to have a focus, yet gave some flexibility to the participants' delivery of material.

This framework allowed me to elicit rich material from the participant's experiences, by using the questions, prompts and interview techniques to stay focused. Banister et al (1994) believe that this is a good way to tailor the interview to each participant's

responses in order to gain more knowledge, understanding and empathy. Whilst conducting the interview I was mindful to be open, honest and sensitive to the participants (Denscombe, 2003). I believe this also adds validity to this research study (Lincoln & Guba, 1985).

The next stage in the process was to embark on a pilot interview. I performed the semi-structured interview which gave me the chance to check and get used to using the audio equipment, being an interviewer and trialling the interview questions. This was invaluable as several things were highlighted. I discovered that in an interviewer role I became quiet. I found I had become over-concerned at showing any bias in what I might say. It also became apparent that the questions chosen did not focus sufficiently on mitigating vicarious trauma and perhaps would not gain the rich material from the participants in relation to the research title that I hoped for. A second pilot was, therefore, completed with questions more specific to my research title.

I arranged to meet each individual participant at a place of their choice. Four chose their own homes, one came to my home and one chose to be interviewed at his place of work. None of the participants had any special needs. When I arrived to interview the participants, I had with me two tape recorders, audio tapes, extension lead, spare batteries and research paperwork. In all cases the rooms where the interviews took place were quite, private and relatively undisturbed.

Before the interviews took place, I ensured that all relevant information was given to participants and that the research paperwork was completed. Time was taken to establish that the participants were happy with the information they were given, had a

chance to ask questions, and that I still had their informed consent. We both then signed the consent form (Appendix 4). I ensured all the interview questions were asked to each participant in order to insure continuity. I later transcribed the tapes on to the computer, ensuring all identifying material was removed (Le Voi, 2002).

## 2.7: Data analysis.

Leech and Onwuegbuzie (2007) argue that data analysis is one of the crucial parts in qualitative research. When deciding on a method of data analysis I rejected a deductive approach. I felt this would not lend itself to this research, since there is no hypothesis to disprove. I chose, therefore, to use an inductive approach to data analysis, believing it to be a “defining characteristic of qualitative research” (Maykut & Morehouse, 1994, p.126).

Transcribing is an important part of the data analysis process, which Denscombe (2003) supports, believing it immerses the researcher in the data. Having completed the transcribing, I began to unitise the data using a constant comparative method of analysis to analyse the data derived. This method comes from the grounded theory approach (McLeod, 2003; Strauss & Corbin, 1998). I have, however, used Strauss and Corbin's second approach to data analysis, which whilst accepting some interpretation is necessary, focuses more on description. Their third approach focuses on theory building and, therefore, needs more interpretation (Maykut & Morehouse, 1994, p. 122). This process allows the emergence of propositional statements and allowed me to keep as close as possible to the participant's thoughts, feelings and behaviours, therefore, being more descriptive than interpretive (Maykut & Morehouse, 1994).

Each participant was given an indentifying code so that anonymity was ensured. The code used was taken from Maykut and Morehouse (1994, p.127) in the following format. T/A-5 is as follows: The T identifies the material comes from a transcript. The following letter identifies individual participants and the number following identifies the page number of that person's transcript. Whilst transcribing I kept a discovery sheet at hand to record any developing themes (Maykut & Morehouse, 1994).

Having completed this process, I printed off each transcript onto different coloured paper; this helped me identify each participant visually, more easily. The text was then broken down into units of meaning, grouped together into themes or categories. This process was repeated several times looking for emergent themes (Appendix 7 & 8). From these, I was able to write propositional statements (Appendix 9) from the emerging themes (Maykut & Morehouse, 1994). See Appendix 11 for a fuller description of the data analysis process.

## 2.8: Limitations of the study.

A limitation of this study is that due to the nature of qualitative research and the vast amount of data collected, only six participants were used (Denscombe, 2003; McLeod, 1999). I acknowledge that by being a small scale study, my sample is not a complete representation of all counsellors dealing with client's traumatic material. McLeod (2003) may argue, however, that it may be a reflection of counsellors dealing with traumatic material. As I was not actively looking for participants of different gender, age, sexuality or culture this may also limit the study.

Researcher inexperience is also a potential limitation of my study. West and Byrne (2009) argue that this could not only harm the research but also the participants. I feel, however, that the procedures put in place above will help to lessen the effects of this. A number of issues were raised in the pilot study (See above).

A further limitation may be that my primary role is that of a counsellor. Whilst conducting the interview I was mindful not to become the counsellor and remained in the role of interviewer. It was a requirement of the participants to have access to personal therapy if issues were triggered in the participant. In order to safeguard myself and my participant, I too had access to personal therapy and a research supervisor to oversee the study (West & Byrne, 2009; Bond, 2004a; Bond, 2004b; Lincoln & Guba, 1985).

Moving into the next chapter I will outline the results of this research study, with illustration from the participants themselves.



## **Chapter 3:**

### **Presentation of outcomes.**

#### **3.1: Outline of propositional statements derived.**

The data analysis process produced thirty nine initial categories (Appendix 7) reflecting all the information transcribed from the six participants who took place in this research study. These categories were then re-analysed producing nineteen revised categories (Appendix 8). This was then used as the foundation for producing fourteen propositional statements (Appendix 9), which are listed below.

1. Participants remember a different frame of reference prior to working with traumatic client material.
2. Participants experienced a change in their frame of reference as a result of working with traumatic client material.
3. Participants were aware that clients' traumatic material had had a significant impact on themselves.
4. Participants experiences of how traumatic client material has impacted on them.
5. Participants recognised the need for self-care when working with traumatic client material.
6. All participants indicated that they used strategies to mitigate vicarious trauma.
7. Participants found their own natural way to mitigate the effects of vicarious trauma.
8. Successful outcomes with clients made the counselling process worthwhile for the participants and, therefore, helped to mitigate vicarious trauma.

9. Participants showed post traumatic growth after dealing with traumatic client material.
10. Participants found talking a useful strategy for mitigating the effects of vicarious trauma.
11. Participants felt that supervision should work towards mitigating vicarious trauma, however, it fell short of their expectations.
12. Participants found barriers in using clinical supervision to mitigate the effects of vicarious trauma.
13. Not all mitigating strategies worked for each individual participant.
14. Participants felt they could do more to mitigate the effects of vicarious trauma than they were doing at the time of the interview.

I will outline these individually below.

### 3.2: Propositional statements.

#### 1. Participants remember a different frame of reference prior to working with traumatic client material.

All participants were able to reflect on their pre and early counselling lives and recognise that they were operating from a different frame of reference back then compared to where they are now.

- *I was never, never naive because uhm uhm I worked (removed identifying material) uhm in my local area for uhm quite a number of years so I'd heard a lot of stories and I've heard a lot about what went on in the world uhm and I think I beli but I still think even at that point I think I still believed that people were good uhm and they deserve trust and*

*respect uhm I guess really I suppose I thought everybody's a bit like me and that they're hard workers and you know they try to do their best uhm.*  
(T/A-1).

- *I was in a very different place at that time, I was just coming through a horrendous divorce so in some ways the beginning of that training was ill timed umm so I was in a very troubled place umm in shock.* (T/B-1).
- *I've always got had quite a broad view of uhm outlook and uhm preferential peoples choices but uhm certainly when it came to peoples actions and behaviour I was quite black and white before I started my training.* (T/C-1).
- *I suppose I was very much uhm I wasn't aware of a lot of uhm assumptions and prejudice, ideas uhm judgement uhm the words that we use in counselling I wasn't really knew about that type of work and how we operate very much about me and the world how I I wasn't it I didn't understand as, as I do now that I've had my training about how I am.*  
(T/D-1).
- *Spirituality is uhm brer I was very confused uhm not in a bad way I was probably more open to other things coming to me outside influences I had no specific view of my spirituality until uhm how I interact with people I was very aware of my families uhm I suppose I didn't know in those days uhm how other peoples values compared to me uhm.*  
(T/E-1).
- *Myself was very lacking in confidence uhm lacking some awareness of what was going on within me.* (T/F-1).

## 2. Participants experienced a change in their frame of reference as a result of working with traumatic client material.

All participants participating in the study reported a change in their own frame of reference since engaging with their client's traumatic material. Participants were found to have been affected in various ways. Some displayed puzzlement at the way people behave in the world and disillusion at clients' behaviours. Most commented on

gaining a new and perhaps more cynical awareness of society. A loss of trust was evident in several cases. Fears over loved ones vulnerability in society and a resignation as to the ongoing effects of undertaking this counselling work were also discussed.

- *Maybe people aren't like me and maybe people aren't as trustworthy.*  
(T/A-3).
- *I don't think I take things quite so much at face value as I used to.*  
(T/A-7).
- *It's affected my eh,eh, eh, eh psyche in some, in some way.* (T/B-4).
- *I could somehow still identify with it as imagine happening to me in the community in which I live even there's a little hint of such a thing if I felt that my child was vulnerable in that sort of way when he stepped out onto the street er I would be immensely distressed and it would colour my life quite differently.* (T/B-6).
- *Dramatically, dramatically changed.* (T/C-1).
- *I'm hugely affected with by the, the general harshness that can be around.* (T/C-2-3).
- *Through awareness through uhm looking at, at the search word looking how uhm the search has been done how we behave how we interact how our views are governed by society uhm and how it all comes together it's changed my outlook completely.* (T/D-1-2).
- *Certainly regards to spirituality has changed.* (T/E-1-2).
- *I'd say that hearing about sexual abuse physical abuse, ongoing physical abuse and sexual abuse where it's unmit people has been unmitigated has really opened my mind up to what goes on out there.* (T/E-2-3).

- *Spirituality I've been through a time of doubt and uhm confusion over what's going on but then I've also come into the awesomeness and magnificence of God as I look at of all of creation and realise that I don't have the answers so actually my faith has got a lot deeper but a lot a lot realistic and prepared to question but prepared to allow mystery. (T/F-2).*

### 3. Participants were aware that clients' traumatic material had had a significant impact on themselves.

Participants reported that dealing with severe traumatic client material such as child sexual abuse, male/female rape, torture etc. had had an impact on themselves. The research also suggested that there were clear signs that the volume and severity of client traumatic material had overwhelmed most of the participants at times. Participants reflected how hard it could be to accept, believe and understand the depths shown by some perpetrators.

- *Since then I've, I've dealt with a lot uhm particularly around sexual abuse uhm of women but also of men and the impact that can have has been quite uhm quite traumatic. (T/A-5).*
- *I think to know that somebody can do this to a child of three or four or even I mean I'm thinking of a poor man that I knew who was raped in prison uhm and an it happened twenty years ago but he's still trying to get his head around why somebody would do that uhm so I think that er I've heard a lot of material but I think what struck me I mean everything that sort of struck me per... professionally but I guess they had an impact on me personally. (T/A-5).*
- *I am aware of of uhm of traumatic stuff which I have come across and, and the degree of disturbance it's brought. (T/B-3).*
- *Some issues have been very disturbing discoveries to me. (T/B-3).*

- *I think the most traumatic aspect of my of what client's bring is .....the harshness of society upon them and how they perceive themselves how good or bad really uhm the impact the social impact that er that that that the clients are left with separate maybe from the individual trauma but then the social impact of it that's definitely been a huge highlight for me.*  
(T/C-2).
- *It's left me with a a and when I'm talking to you about this particular client I feel aww he talks about the scene and it's absolutely horrific and I can sometimes recall a picture.*  
(T/D-4).
- *I'd say that hearing about sexual abuse, physical abuse, ongoing physical abuse, and sexual abuse where it's unmit... people has been unmitigated has really opened my mind up to what goes on out there.*  
(T/E-2-3).
- *I think what really affected me was the graphic descriptions of their experiences which they needed to express and I needed not to react to.*  
(T/F-2).

#### 4. Participants experiences of how traumatic client material has impacted on them.

Participants reflected on a number of ways of how experiencing traumatic client material had impacted on themselves. Anger, frustration and shock at the perpetrator, client and themselves were all themes. Experiences of sadness, being troubled, disturbing imagery and feelings of isolation from family, friends and colleagues, were also present. The participants also reported incidences of impact on their beliefs, in the form of bewilderment, wondering why people behave in such ways and how family and friends can also be perpetrators. The research data also highlighted that participants also experienced physical changes/feelings during and after counselling sessions.

- *I often feel things when I'm with clients I feel in my stomach as well so uhm I actually feel a physical sensation in my stomach butterflies or a sinking feeling uhm so yeah I I think that has an impact on me. (T/A-11).*
- *Think sometimes it makes me feel, feel quite weary and sort of worn out and tired. (T/A-7).*
- *I was shaken by the event I brought it home I was unable to sleep that night, I was truly unable to sleep that night. (T/B-4).*
- *The power of the disturbing imagery remained, in fact they remain with me now. (T/B-4).*
- *Frustration for sure I get very frustrated and uhm and I probably get quite angry. (T/C-7).*
- *I feel quite alone with this sense of being all wound up and uhm entangled within myself and it's quite a lonely place. (T/C-7).*
- *There is no verbal expression yeah yep er so frustration and isolation are really the route of of what will be the outburst which will be anger (she laughs) really. (T/C-7).*
- *Physically I go a little bit goose bumps appear sometimes if the stories horrific. (T/D-7).*
- *Emotionally I do get threatened. (T/D-8).*
- *I wonder at the world at times uhm but again I realise that I have no control over certain things that go on uhm I wonder why people perpetrate such crimes uhm I wonder sometimes why people stay in abusive relationships. (T/E-6).*

- *Physically I get very drained absolutely drained umm sometimes I get angry you know a sense of the injustice of it what's happened sometimes I can get a bit afraid.* (T/F-5).

##### 5. Participants recognised the need for self-care when working with traumatic client material.

Awareness by participants of the importance of self-care was evident throughout the data collected. There was an acknowledgment that this was central to being fit to practice and support clients. It was also highlighted that the bigger the impact by client traumatic material, the sooner there may be a need to “off load”. Interestingly, all the self-care carried out appeared to be after the therapeutic session, no mention of any thought of self-care during therapeutic sessions was recorded.

- *I know I have to look after myself I am very big in a uhm sort of er big believer if you cannot look after yourself, you cannot help look after other people and support other people.* (T/A-8).
- *What I tend to do is really do a lot of self-care and not not in not nothing in the session but certainly after the session yeah. If I'm left with feelings of traumatised myself and that twilight zone as I call it between my trauma and their trauma where there's two different traumas, but very similar effects of and so I do a lot of self-care of myself and I do I actually do a lot of digging just digging.* (T/C-5).
- *There are clients that come with very emotional and graphic stuff umh that sometime you hold until you've had somewhere to go with it.* (T/D-3).
- *I make sure I, I look after myself at weekends and just generally make sure that I do all the things that I would normally have done ten years ago before I started training umh and I don't work full time as a counsellor umh I do three days a week decorating painting and decorating and I find that's very therapeutic umh it allows me to detach*



*totally so when I go back I on a Monday or Tuesday and perhaps do some private work I I'm more focussed.* (T/E-5).

- *So I'm taking care of myself by walking and setting up this programme.* (T/F-8).

6. All participants indicated that they used strategies to mitigate vicarious trauma.

Analysis of the data suggested that strategies were employed by all participants to mitigate the effects of vicarious trauma. These strategies varied from shutting client material out of their minds, sharing the emotional impact with a loved one, taking time out of their everyday life to gain a clear mind, writing notes down after a therapeutic session and physical activity.

- *I try very hard not to carry the feelings around. I think that's a strategy I probably really do use.* (T/A-12).
- *I actually discussed this with my wife, umh, er because I couldn't think I discussed this with my wife, umh and it was helpful to be able to let somebody close to me know how troubling, how troubled I was.* (T/B-5).
- *I physically go down the garden and dig.* (T/C-5).
- *I think that's a strategy that I do use is to do write things down after the session around the session or anything in that session that I need to make a note of I've always put that at the bottom at the end of the session that is what I've found has been very useful uhm.* (T/D-12).
- *I think what I'm doing is sifting I'm I'm, I'm separating I'm doing a process of separating you know because when I'm digging I'm taking the weeds out and moving the soil so I think what I do is I do that sifting out.* (T/C-5).

- *I've taken on a different view dealing with clients and their vulnerability that I recognise that in myself. I also recognised the need that you have to take time out on account you have to clear your mind totally er I'm very very aware of burnout recognise the signs.* (T/E-2).
- *I learnt to immediately take, after the session to take a break in somewhere beautiful to get that balance back their experience was their experience and horrendous so I couldn't stay in it I had to take a step before coming back to normal life.* (T/F-2-3).

## 7. Participants found their own natural way to mitigate the effects of vicarious trauma.

Although it became apparent from the participants interviews that they all had their own individual way of mitigating the effects of vicarious trauma, there were some strong themes that emerged. Talking to another counsellor straight after experiencing a client's traumatic experience appeared to have a mitigating effect on the amount of material being held by the participant. Being able to "off load" relatively soon after a session appears to make a significant difference to the effect the traumatic client material had on the participants interviewed.

- *We can come out and we can speak to another therapist so we can almost have an off load.* (T/A-10).
- *It was helpful to be able to let somebody close to me know how troubling, how troubled I was.* (T/B-5).
- *I guess being married to another counsellor is a bit of a cheat but it's quite nice to speak about a client.* (T/B-8-9).
- *If a client threatened to commit suicide I'd have to go to someone at work a colleague to say what do you think I should be doing and it's just*

*talking it through and getting some sounding board from colleagues and that's been helpful at times.* (T/D-13).

A further theme was writing, perhaps in the form of client notes or creative writing. This appeared to produce an avenue to expel unwanted information, emotions and thoughts, onto a separate vessel to alleviate the participant from holding onto unpleasant feelings, memories and imagery.

- *Clients they come in they leave I write down my notes and then I try to let that go.* (T/A-12).
- *I have found that writing helps.* (T/D-5).
- *I think that's a strategy that I do use is to do write things down after the session.* (T/D-12).
- *I wrote some poetry some years ago and uhm I keep meaning to go back to it.* (T/E-8).

Physical activities were also employed by some participants' to help them process troubling material, categorise thoughts and escape life for a while.

- *I do a lot of self-care of myself and I do I actually do a lot of digging just digging.* (T/C-5).
- *I will either sort through my cloths sort through my son's cloths sort through books or sort through the the of the soil. So my strategy is to do a process of sifting and putting things into into compartments really so I can deal with them.* (T/C-6).

- *I do three days a week decorating painting and decorating and I find that's very therapeutic uhm it allows me to detach totally.* (T/E-5).
- *Make sure I'd worked it through in my mind what's going on.* (T/E-4).

Participants highlighted their awareness and the value of self-care, balancing life and work load.

- *I make sure I look after myself at weekends.* (T/E-4-5).
- *I need to constantly review the balance I have in life.* (T/E-11).
- *I've set up a... every six or four to six weeks I would have a massage.* (T/F-4).

Further mitigating strategies included listening to music, reflection, faith and not allowing work to intrude in their home life.

- *I think what I do is after the client's gone I sit back if they've had an effect on me I just sit and reflect and how why has that had an effect on me. Is it my stuff getting into there or is it just their stuff.* (T/D-9).
- *I think also making sure that when I close the door of an evening that I'm shutting out that.* (T/E-4).
- *I will use my music I will use my reading.* (T/E-6).
- *I read I'm an avid reader I read a lot stuff by Dee Henderson and David Spurn and umm I like good wholesome novels. I don't read anything with*

*trauma in it I just don't I cross stitch umm and I knit and I do Hanji puzzles.*  
(T/F-7-8).

8. Successful outcomes with clients made the counselling process worthwhile for the participants and, therefore, helped to mitigate vicarious trauma.

The majority of participants felt that there were positive aspects of working with traumatic client material. Watching clients move on from their trauma appears to reward the participants in various ways. Powerful, rewarding and empowering statements were offered during the interviews, giving a message that it felt good to be able to make a difference to a client. These effects suggest a mitigating effect on the depth of vicarious trauma felt by participants.

- *Of course that refers to triumph as well as disasters as it were sometimes I do come home with a smile on my face and I think God God I was good there.*  
(T/B-9).
- *P: I've actually made a difference today B: O yes it's a very good feeling isn't it when that does happen it's a very good feeling without a doubt, without a doubt (both laugh).*  
(T/B-9).
- *I feel quite celebratory in a way that I feel wow this is good work this is something I've helped this person to move on even though they've done all the work it's just being behind them to push them along so it's quite a way it's not a sort of a arrogant way thinking oh wow I've done this it's not about I've done this.*  
(T/D-6).
- *It's great to be able to say to somebody you don't need to come back to counselling again you've achieved what you want to achieve and there's the door in the nicest way in the nicest possible way.*  
(T/E-9).

- *Oh I jump up and down inside ..... it's wonderful to see somebody move forward I think Barber talks the I Thou moment and that is within the session but sometimes you're coming on you know and the clients are not aware of it but you see it and you think yes you've got it and your coming on and then you gradually see them drifting away from you and you think yeah that's great part of you doesn't but part of you does you know.* (T/F-9).

9. Participants showed post traumatic growth after dealing with traumatic client material.

Participants showed a spiritual growth in witnessing clients' courage, tenacity and inner strength. They felt that they had gained wisdom, hope and a positive outlook when clients changed a negative event into a positive outcome. They, therefore, felt this may transfer to themselves in their own lives. Participants also expressed that they valued their personal relationships more; enjoying more what they already had in life, as a result of the material they dealt with.

- *One of the positive ways, is it's made me thankful for my own relationship.* (T/A-6).
- *Enjoy the things that are there the things that we do have.* (T/A-8).
- *That's been the get out clause for me that she was able to resolve it herself, very skilfully and successfully eh, none the less, er I shan't be able to forget how troubling to me her problem was.* (T/B-4-5)
- *Oh my lord how can this guy or person manage to do what he did do or what she did so it's about how brave how how uhm this persons found the strength how wonderful in a way that this person could of managed to do what they did at the time so it's about I suppose in a way it's been that I've seen wow you have got inner strength.* (T/D-4).

- *I'm seeing people in similar situations now, I use that as part of my ongoing continuing professional development if you like that I'm using the experiences of other people and I bring that into the counselling to help other people.* (T/E-4).
- *I'm very appreciative of what I have and I'm very I use the term blessed you know in what I have.* (T/F-6).

#### 10. Participants found talking a useful strategy for mitigating the effects of vicarious trauma.

Talking to partners, colleagues and even themselves was one of the strongest themes to emerge from the participants' interviews in relation to mitigation of the effects of vicarious trauma. At times there appeared to be an urgency to alleviate the need of holding onto traumatic client material in order to mitigate the emotions surrounding this. This strategy appears to be a way of processing the information, emotions and thoughts gained from the traumatic client material.

- *I talk to my partner sometimes about certain things and I don't necessarily give details but if there is something I need to understand or you know I do tend to talk.* (T/A-12).
- *I actually discussed this with my wife, umh, er because I couldn't think I discussed this with my wife, umh and it was helpful to be able to let somebody close to me know how troubling, how troubled I was.* (T/B-5).
- *The other thing I have got is colleagues at work if there is anything that really I mean straight away there are colleagues at (name removed) that are available if there's not one there's someone else so there's plenty of people around I can go to if I need to.* (T/D-12).

- *If a client threatened to commit suicide I'd have to go to someone at work, a colleague, to say what do you think I should be doing and it's just talking it through and getting some sounding board from colleagues and that's been helpful at times.* (T/D-13).
- *I do sound off at the end of the day you know P: ... to your wife? E: Yes, and obviously we don't mention names or anything and it's nice I don't work I work 22 miles away over 22 miles away from my work uhm and that's quite important I think.* (T/E-4-5).
- *I have friends I can contact too and therapists I can go to.* (T/F-4).
- *I've actually got I will have a debrief which is my one in (referring to specific supervisor) and if I need to I'll fly out there and spend time out at the base there which they've got this debriefing centre that they use.* (T/F-7).
- *It's a place I can go; it's completely private I can mumble to myself.* (T/C-8).

In relation to not talking:

- *I think when I feel I have really missed the boat with someone that I don't make best use of the support that's with me around me my supervisors maybe my colleagues if appropriate and I'm really not good when I when I made the decision that I really missed the boat it's almost like it's so awful I can't take it anywhere.* (T/C-8).



11. Participants felt that supervision should work towards mitigating vicarious trauma, however, it fell short of their expectations.

Participants voiced their opinion that they valued supervision; however, five out of six participants felt that in some way it did not meet all their needs for various reasons. The stigma of being seen as incompetent was highlighted as a concern. Not being able to openly share their dilemmas was commented on and contacting supervisors between sessions seemed to be difficult and time consuming. At times supervisors were seen as being judgemental, less than helpful, refusing to deal with difficult material and sometimes unwilling to listen.

- *I think with the supervisor I've got at the moment, no and I think when I talk about... if I talked about some of the things we've been talking about today, I think she would dismiss them as not particularly important and par for the course and I'm and I'm.. so I think that's where my ambivalence to supervision comes from. (T/A-9).*
- *I took it to supervision and didn't find satisfactory answers there, I took, in fact I took it to two supervisions and didn't feel a sense of solution out of either of them. (T/B-4).*
- *I'm so absolutely disappointed in myself I don't want someone else to see just how badly I can get it wrong (both laugh). You know uhm and and it's mad because I'm human I have all the pressures of life that everybody else has and er it it doesn't make sense but, but that's definitely where I should go with it. (T/C-9).*
- *I want to be able to go and talk about it now cause it's fresh it's there but I suppose if it's about a week or two later it doesn't hold the same impact to describe how I feel I sometimes lose some of it by the time I get to supervision. (T/D-5).*

- *I had two before uhm one who wouldn't deal with certain issues.....that would have been a real problem today because she wouldn't deal with any sexual issues which you know that's life in my opinion she shouldn't have been a supervisor.* (T/E-7-8).

## 12. Participants found barriers in using clinical supervision to mitigate the effects of vicarious trauma.

Participants discussed a number of individual barriers to using supervision effectively. Difficulties in simply contacting the supervisor outside of supervision times, the availability and response time of the supervisor, were all seen as barriers to effective supervision. Not being able to connect with their supervisor created distrust, leading to being unable to share their whole self within the supervision process. Incidences were put forward of how supervisors had become dictatorial in how the participant should counsel their own clients, hence subjugating the participants views, feelings and expertise. This was compounded at times by not having free choice of supervisors, linked to organisational procedures, which insisted participants used internally sanctioned supervisors.

- *One, it's provided by my work so I'm stuck with that, but I can't even go off and, and get a private supervisor cause I actually can't afford to do that.* (T/A-9).
- *I haven't felt an intense relationship with a supervisor to a degree that lets me reveal the whole of myself in a given supervision.* (T/B-8).
- *I think when I feel I have really missed the boat with someone that I don't make best use of the support that's with me around me my supervisors.* (T/C-8).

- *I put myself through tremendous pain and angst before I can kind of then go and say this happened and it's almost like I wait until it's, it's more safe you know it's as if I'm saying I was really down but I'm not down any more but that doesn't help you in the time that you really need I really need.* (T/C-9).
- *Going to that supervisor is a long winded process and you've lost the essence then and time is of the essence when you are feeling the way you are.* (T/D-13).
- *Uhm and another one who was a bit too judgemental about my client's and I don't want someone being judgemental about my client's uhm I try not to be uhm and that person doesn't have a right to do that and was perhaps a little too directive and you should go back and try this instead of about trying this and I would come out of the supervision session thinking and just like a client would not with a set of rules to go back into next Monday or Tuesday session at the surgery I don't direct my client's but I don't want a supervisor doing the same I want to go out feeling refreshed and always do always do.* (T/E-8).
- *Occasionally something arises as it does.* (T/F-4).

### 13. Not all mitigating strategies worked for each individual participant.

As discussed above, one constant theme from all participants was that they believed in the value of supervision. Each participant, however, felt that they did not or could not fully engage with their supervisor, leaving them holding onto some of their client's traumatic material.

- *I think supervision I think it used to be and I think that's actually something to do with my supervisor and I had strangely enough tried to tackle it with her but again it just gets pushed away and then it doesn't get done.* (T/A-13).

Participants were also each able to identify other strategies that they had tried, however, had found, in their experience, did not mitigate the effects of vicarious trauma. These included eating chocolate, physical exercise, loose boundaries, non-physical pastimes and connecting by self-disclosure with clients.

- *I don't think eating chocolate is very effective I think I feel better at the time but I think I get bigger and bigger and then I get disappointed with myself so I don't think that's worked at all.* (T/A-12-13).
- *I think physical exercise is one that is supposed to be good for you uhm you know in lots of ways and I don't necessarily find it useful and I think the reason I do that is because I get too tired.* (T/A-13).
- *Contemplation without physical outlet definitely I can't just sit and reflect without that physical connection of literally sorting it goes hand in hand with me am quite a physical person.* (T/C-8).
- *Loose boundaries.* (T/D-11).
- *I think possible uhm where I thought personal disclosure was relevant.* (T/E-9-10).
- *Eating that was very temporary. Yes that's right I can't think various types of games or things on the computer or you know umm sort of puzzles tried it don't like it don't do it. Umm so yeah I suppose those I tried doing aqua aerobics but that did not work for me.* (T/F-8).

14. Participants felt they could do more to mitigate the effects of vicarious trauma than they were doing at the time of interview.

Participants all identified areas where they appeared to be aware of a need to mitigate the effects of vicarious trauma, perhaps more than they were doing at the time of the interviews. Better self-care was at the fore-front of most participants minds.

- *I probably need to look after myself a bit better.* (T/A-14).
- *To look after me because I don't want to be affected by the trauma.* (T/C-5).

Reading and writing was favoured by some participants, being creative through dance, art and poetry, were among other suggestions.

- *I'd like to dance I would like to do art and be creative I'd like to have some extra things that I find fun to do.* (T/A-13).
- *I might do some writing about it and that will take away the space they're taking within me out.* (T/D-7).
- *I'd rather do some reading.* (T/E-8-9).
- *Write a few things down and see where it takes me and forget about where the end result might be.* (T/E-11).

Connecting with nature and relaxing, accepting support, and keeping a balanced life were also strategies discussed by participants.

- *Wouldn't that be nice, just to get away for a week somewhere and relax and recharge your batteries?* (T/A-13).
- *I think when I feel I have really missed the boat with someone that I don't make best use of the support that's with me around me my supervisors maybe my colleagues if appropriate.* (T/C-8).
- *I need to constantly review the balance I have in life.* (T/E-11).

And education.

- *Anything I have not done. I desperately want some further training umm so I would say that's something I have done is I have gone on on going training in trauma, trauma in the body you know that sort of work umm that I would love to have some more training.* (T/F-9).

### 3.3: Summary of results.

Participants were aware that they had changed as a result of working with traumatic client material. Participants showed a keen awareness of how traumatic client material had impacted on them. Each participant had developed their own individual strategies to mitigate the effects of vicarious trauma; however, participants identified more could be done to alleviate the effects of vicarious trauma.

The strongest theme to emerge, which also challenged existing research, was that, although all participants identified supervision as a potentially mitigating factor, supervision often fell short of participants' expectations. This left them short of essential support in dealing with traumatic client material. A second theme was around positive growth, which appears to have acted as a mitigating factor to

vicarious trauma for participants in this study. This experience encouraged them to stay in the counselling profession. These results will be discussed in more depth within chapter 4.

## **Chapter 4.**

### **Discussion.**

The participants in this research study answered questions in the semi-structured interview about how their client's traumatic material had impacted on themselves (appendix 6). All reported clear examples of the symptoms of vicarious trauma, for example; intrusive imagery, anger, fear, sadness, sleeplessness, tiredness, loss of trust and feeling isolated. The participants directly linked these symptoms to their work with traumatic client material. These examples are congruent with previous research in this area (Canfield, 2005; Saakvitne, 2002; McCann & Pearlman, 1990).

Even though the symptoms of vicarious trauma experienced by the participants were many and varied, there were common symptoms that were experienced by most participants. Fear had a major impact on participants' lives. Participant B clearly displayed this symptom of vicarious trauma after listening to his client's story of her daughter being bullied outside of her home. This knowledge touched the participant in such a way that he was fearful that his own son may encounter the same thing. This was something that participant B had never envisaged before hearing his clients traumatic tale and it changed his view of the world. This finding supports Schauben and Frazier (1995) who argue that "the beliefs most likely to be altered are those involving the goodness of other people" (p. 51). Meyer and Ponton (2006) add that it is the negative changes in their beliefs about the world and increased negative emotion" that creates this fear (p.191).

Sadness, as noted by Sexton (1999), was a further symptom that appeared to affect five out of the six participants. Participant D explained that when she engaged



empathically with her client, whilst recounting her traumatic story of a car accident, the pictures she visualised created an understanding of the pain the client had gone through. This left participant D with an overwhelming sadness that has stayed with her. Neumann and Gamble (1995) recognise that this type of intrusive imagery is painful and a common sign of vicarious trauma. They state this is to be expected when facilitating trauma work.

Physical symptoms of vicarious trauma were also mentioned by five out the six participants during the interviews. They explained how the effect of listening to the client's traumatic material left them drained, weary and worn out. Participant A commented on how her loss of trust in her clients has affected her world view and spoke of how this had made her feel so worn out and tired. This illustrates the fact that the effects of vicarious trauma may be emotional, psychological and/or physical and they appear to be interlinked (Herbert & Wetmore, 2008).

The analysis of the data went on to show that, all participants had put in place strategies to help mitigate the symptoms of vicarious trauma, from the effects of dealing with traumatic client material. Taking into account Pearlman and Saakvitne's (1995) view that vicarious trauma is unique to each counsellor; it makes sense that the participants' response to this pervasive effect would be as diverse as the origins. This appears to be the case and each participant seems to have found their own natural way to ease the effects of how their clients' traumatic material has affected them. There were, however, themes that emerged throughout the study of what strategies mitigate the effect of vicarious trauma.

A strong theme was talking to colleagues, partners and themselves at times, which had been utilised by all of the participants. This is consistent with research by McCann and Pearlman (1990), whose research shows this to be a strong mitigating factor and to be encouraged (Herman, 2001; Etherington, 2000). Three participants talked to their partners about traumatic client material that had been imparted to them. Participant B shared “how troubled” (T/B-5; p.44, N.B. when referencing participants’ quotes the page number relates to this dissertation) he was to his wife and participant E would “sound off at the end of the day” (T/E-4-5, p.45), to his wife. Three participants sought peer support from work colleagues and participant D valued being able to see colleagues “straight away” (T/D-12, p.44).

Participants appeared to gain varying things from the talking process. Being able to illicit validation for actions taken, perhaps suicidal clients, created confidence, empowered and confirmed their belief in what they had actioned. Herman (2001) endorses the use of professional support which allows the counsellor to be open, honest and forth coming in sharing their thoughts, fears and concerns. Sometimes, however, the participants were unable to do this (discussed below). McCann and Pearlman (1995) highlight the importance of establishing a professional network of support, as do Harrison and Westwood (2009). Other participants took advantage of different avenues and gained an acknowledgement from their partners that they were hurting, suffering and troubled by what they had brought home from their clients. This further supports Bober et al’s. (2006) view of the importance of developing personal and professional support networks to mitigate the effects of vicarious trauma. This strategy is also consistent with Schauben and Frazier’s (1995) research which found that using emotional support was an effective coping strategy.

Other strategies disclosed by the participants in this study revolved around physical activity. These included physically sorting, shaping and disentangling of garden material and house items, as well as decorating. Participant C goes “down the garden and digs” (T/C-5, p.38) as a process to clear her mind, whereas participant E uses decorating to detach in a therapeutic way. This may emulate the thought process of sifting through the traumatic client material in order to section, compartmentalise and store the processed material safely. It could be argued that this physical exercise enabled the participants to contain the stress they felt, until they were able to dissipate it through physical movement, leaving them de-stressed and clear headed (Rothschild, 2006).

Writing was also a strategy that was found to be useful for the participants in this research study, which is consistent with the research literature. This was especially in regards to writing client notes at the end of a session, in order to leave the material behind and to mitigate the effects of vicarious trauma. Participant A writes her notes and then tries to let go of the material. Participant D would “write things down after the session” (T/D-12, p.40). Some of the participants adopted this strategy, finding it a positive way of sorting out their thoughts and feelings at the end of counselling sessions. Others leaned more towards creative forms of writing, participant E had found writing poetry to be particularly useful.

A further finding from this study was that all participants showed their awareness of the importance of self-care and this topic was commented on several times during the interviews. This may be viewed as a mitigating factor in its own right. Participants valued their mitigating and coping strategies. They could recognise when they may need to instigate these, sooner rather than later, due to an increased level of

traumatic client material being held onto by themselves. Harrison and Westwood (2009) support the view that the education of counsellors in self-care may be of value. Neumann and Gamble (1995) argue that counsellors should consider the importance of self-care, commit to ensuring their own wellbeing and understand their ethical responsibility in this matter. It can be argued that without this measure in place, it may increase the risk to the client of becoming damaged by the counsellor.

During the interviews participants also acknowledged that they could do more to mitigate the effects of vicarious trauma, potentially by using their current strategies more. Some participants, however, identified new strategies that they would be willing to, and thought they should, trial in the future. Interestingly no participant considered using any form of mitigating strategy whilst in the counselling session. Rothschild (2006) argues that there are many techniques that could be employed to lessen the impact of the client's traumatic material on counsellors. None of the participants interviewed, however, discussed or seemed aware of this avenue during the interviews.

During the semi-structured interview I asked participants, what strategies they had previously employed that had not worked? The response was as varied, contrasting and individual as the ones that did work. Participants A and F disliked physical activity, whereas, participant C stated "contemplation without physical outlet" (T/C-8, p.49) was not an option. Eating had been employed by some participants at times, however, the side effect was increased weight gain, which dismissed this as a useful mitigating strategy. This is supported by Phoenix (2007) who distinguishes between healthy and unhealthy mitigating strategies. Most participants had tried various

mitigating strategies, however, were self-aware enough to know when one worked for them and one did not.

Supervision was also a major theme within this research study and produced surprising results. The majority of literature strongly suggests that regular supervision is a strong mitigating factor in managing vicarious trauma (Baird & Kracen, 2006; Canfield, 2005; Pearlman & Mac Ian, 1995). Within this research study all participants believed emphatically that supervision was a good mitigating strategy. Participant E responded to a question in his interview about what strategy counteracts the negative effects of traumatic material on him, by stating that he believed supervision to be the primary one. Participant A shared her view of supervision and believed that when it worked it was beneficial. Participant F viewed her supervisor as being “very wise” and used supervision to gain enlightenment in ways to mitigate the effects of vicarious trauma. This is consistent with previous research (Etherington, 2000; Sexton, 1999). Harrison and Westwood (2009) agree, stressing that clinical supervision acts as an important protector for vicarious trauma.

It is at this point, however, that the research findings from this study diverge. Whilst believing supervision is necessary and a good strategy, most participants disclosed that they did not use it to its full potential and some stated that it actually did not work for them. Participant A felt that her supervisor pushed away important material she brought to supervision. Participant B commented on how he could not find “satisfactory answers” (T/B-4, p.46) from his supervisors, even though he approached both of his supervisors with the same matter. Participant E found his supervisor to be “too judgemental” (T/E-8, p.48) about his clients. This finding was a surprise, as I am unaware of research that has investigated clinical supervision not

meeting or fulfilling the expectations of counsellors dealing with traumatic client material. The participants offered several different reasons for this.

One reason for this, voiced by the participants in this study, was concerns around supervisors not wanting to engage in material that they had presented at supervision. Participant E believed this was due to its unpleasant content. Participant A felt her material was sometimes dismissed as unimportant. Some participants reported that there seemed to be a lack of connection with their supervisors, which left them unable to disclose troubling case material. Other participants feared being judged as being incompetent. Even when participants did have a good relationship with their supervisor, frustration at not being able to contact them when needed, between supervision sessions, was also highlighted.

Another concern voiced by the participants in relation to supervision was over supervisors being provided for them by the organisation for which they worked. Half of the participants had more than one supervisor and all participants had supervisors supplied by the various organisations they worked for. Brady et al. (1999) clearly outline their expectations of organisations providing adequate support for their counsellors. They argue that an environment that is emotionally supportive, physically safe and respectful to the counsellor should be established. Continuing personal development, further education and importantly receiving regular competent trauma therapy supervision are outlined. This, however, was not the experience of five out of the six participants. Even with these guidelines there is no recognition by organisations that the counsellor may prefer to choose their own supervisor or what may happen if the supervision is not satisfactory.

One explanation of why the supervision received by participants fell short of expectations, may be because it was not specifically “trauma therapy supervision”, as outlined by Pearlman and Saakvitne (1995) (discussed in chapter 1). The participant, therefore, may have been left holding emotions, thoughts and fears instead of having a supervisor with trauma expertise to help support them effectively in these areas. Pearlman and Saakvitne (1995) further argue that, counsellors working with traumatic client material are not receiving adequate supervision, if their supervisors have not been trained to deliver trauma therapy supervision.

Salston and Figley (2003) feel that counsellors are not aware of the need to consider whether their supervisor may have been trained in trauma therapy supervision and I would agree with this. Before I conducted this research I was also unaware of the concept of trauma therapy supervision. Only one participant in the study appears to have had trauma therapy supervision. One thing that came out of the research was that I did not foresee this finding, therefore, did not investigate the concept of trauma therapy supervision with participants. An extra question or two may have shed extra light on this matter. This may be an area for further investigation.

An explanation of why trauma therapy supervision is not more widely known about or used, could be due to the feeling of stigma surrounding counsellors who state they are affected by vicarious trauma. Vicarious trauma is simply not spoken about in professional circles for fear of the counsellor being seen as lacking, incompetent, not strong enough to cope and not as good as others, who do not appear to be affected by trauma work (Herbert & Wetmore, 2008). This finding is consistent with this research study. Two participants voiced a fear of being judged as being lacking as a counsellor, if they disclosed their true emotions about what they had experienced

when engaging with their client's traumatic material. For example, participant C was concerned that her supervisor's opinion of her would diminish if she disclosed certain information, "I don't want someone else to see just how badly I can get it wrong" (T/C-9, p.46). Participant B expressed similar concerns.

Sommer and Cox (2005) suggest that this is a common reason that counsellors do not openly admit to themselves and others that they are affected by vicarious trauma. This was certainly the case for two of the participants in this study. Saakvitne (2002) believes that "our unrealistic expectations for ourselves and each other about professional detachment and "neutrality" can create a barrier of shame that prevents the honest disclosure of the pain and anxiety of the work" (p.446). Participants in this study demonstrated that they were affected by this professional judgement. At times they allowed this to prevent them from delivering the necessary trauma material, and what they saw as their own inadequacies, to their supervisor. Phoenix (2007) argues, that if counsellors who deal with traumatic client material were educated about the negative effects of vicarious trauma, they could "see these as symptoms and not personal failings" (p.124).

The findings of this research study, therefore, suggest that it may be essential to educate counsellors in what to request, expect and value from clinical supervision. I would also argue that supervision will be more effective if counsellors are fully aware of, understand, recognise and accept the effects of vicarious trauma on themselves. It should be noted that awareness is considered to be a major mitigating factor in vicarious trauma. Phoenix (2007) posits that gaining a "knowledge of coping strategies can provide a sense of control" (p.124). They may, therefore, further seek to mitigate its affects by sourcing trauma therapy supervision (Etherington, 2000).



A further progress may also be to encourage supervisors to be aware of how trauma therapy supervision, may enhance supervisors' understanding, acceptance and practice in trauma work. The educating, training and delivery of specific trauma therapy supervision to supervisors may enable counsellors to trust, engage and disclose, in a way they may not be at present. This I feel may be a major benefit to potential and existing clients.

Unexpectedly and interestingly this research study highlighted a further mitigating factor for vicarious trauma that I had not foreseen: the link between positive client outcomes and personal growth for the counsellor. This may have been down to researcher bias, because upon reflection, I was aware that this is evident within the body of literature I have examined. The research suggests that seeing clients overcome adversity, pain and trauma appeared to be a very rewarding, satisfying, and pleasurable part of the therapeutic work.

The participants' stories showed personal-growth when reflecting upon their client's inner strength, resilience in the face of their traumatic encounter and hope that life can change in a positive way. The effect of this admiration for their client's process, is that the participants appear to value their life more and have an increased belief in the strength of a person's character/spirit. This enjoyment is what motivates and keeps them in the counselling profession whilst also enduring the darker side of humanity and the counselling process. Five out of the six participants demonstrated feelings of satisfaction at enabling their clients to move forward in their process. Participant B recalled his "triumphs" (T/B-9, p.42) and how being able to make a difference kept him in the counselling profession, whereas, participant D disclosed a "celebratory" (T/D-6, p.42) feeling at doing some "good work" (T/D-6, p.42) in moving

clients on. Participant F shared that “I jump up and down inside” (T/F-9, p.43) when her client moves forward.

Neumann and Gamble (1995) suggest, that the rewards of undertaking work with clients bringing traumatic material, provides an opportunity to experience a deeper level of caring and joy. By seeing the client use their resilience to overcome turmoil, counsellor self-esteem is increased, feeling that they have made a positive difference to their client's life. McCann and Pearlman (1990) endorse this, adding that the counsellor may have a deeper connection with the client, enhanced empathy and gain hope for future clients and themselves.

## **Chapter 5.**

### **Conclusion.**

During this qualitative research study I have focused on the mitigating strategies employed by the participants, to alleviate vicarious trauma experienced from dealing with traumatic client material. Participants showed an awareness of how traumatic client material had impacted on themselves, and that they had in fact discovered, developed and made use of a number of mitigating strategies. The strategies employed to mitigate vicarious trauma varied for each individual participant, however, certain themes did emerge. These included supervision and talking; lesser themes were writing, physical activity and shutting the client material out of the participants' personal lives. Interestingly, what may have worked for one participant, may not have worked for another. In this study physical tasks were essential for one participant, however, for others they did not help mitigate vicarious trauma symptoms at all.

Self-care was an important consideration for participants, acknowledging that it was necessary for healthy practice. All participants reflected on what coping strategies they used after working with traumatic client material, however, no participant considered that they may be able to adopt and use strategies whilst in the counselling session. This lack of awareness may potentially increase the risk of the traumatic client material impacting on themselves (Rothschild, 2006).

I found myself surprised by two emergent themes that came out of this research study. Firstly, it became apparent from all participants that they placed great value on appropriate clinical supervision, however, all felt it did not deliver the necessary support that they were seeking. Reasons for this varied from, not being able to be

open about troubling material, due to a lack of connection with their supervisor, to a loss of confidence in the supervisor and/or the stigma attached to stating that they are deeply affected by work with traumatic client material.

Secondly, a further theme was the personal-growth experienced by most participants. Seeing clients overcome adversity, let go of their trauma and continue their life in a positive way, rewarded, empowered and gave satisfaction to each participant. This allowed them to believe that they were making a difference to their clients and appears to have been a mitigating factor in itself.

### 5.1: Recommendations.

The research study suggests that there is a strong case to be put forward for trainee counsellors being provided with more education, awareness and training around the area of vicarious trauma and how their client work may impact on them (Chouliara, et al., 2009). Meyer and Pontin (2006) state that this is “consistently recommended in the literature regarding the prevention of vicarious trauma” (p.198). For the counsellors that came forward and then withdrew, because they were not affected by traumatic client material, this may be particularly relevant, given that Pearlman and Saakvitne (1995) state vicarious trauma is inevitable.

I would also argue that it would be advantageous to encourage more professional development in the area of awareness, acknowledgement and acceptance of vicarious trauma for qualified counsellors (Canfield, 2005). All participants in the study did report changes as a result of working with traumatic client material and used their own naturally acquired strategies to mitigate this. Only one, however, was aware of

the term vicarious trauma and the implications it may have on her. The subject of the effects of vicarious trauma on counsellors and how to mitigate against them, therefore, needs to be brought more into the counselling arena, by delivering more publications, seminars and forums around this subject. Public acknowledgement by eminent counsellors may also help break down the stigma that haunts the counselling profession (Herbert & Wetmore, 2008), allowing counsellors to use supervision to better affect. Trauma therapy supervision should also become the adopted standard when supervising counsellors dealing with traumatic client material.

Organisations delivering counselling need to be made aware of their responsibilities in regards to their employees, ensuring that they are up to date with current information, strategies and procedures to help their counsellors mitigate the effects of vicarious trauma. Wheeler (2007) advocates that the organisation can create a caring, supportive and nurturing culture, with understanding management, that can create an environment that reduces stress, bureaucracy and value their counsellors. Sexton (1999) argues these health and safety issues may, if not met by the organisation, leave them open to litigation by their counselling staff.

## 5.2: Areas for future research.

The following areas for future research occurred to me as a result of undertaking this research.

There appears to be a shortage of British research into vicarious trauma, how this may impact on counsellors who engage with traumatic client material and whether

they attempt to mitigate the effects this work has on them (Chouliara et al., 2009). Supervision was a main theme in this research study and participants felt it did not always fulfil their needs. I would, therefore, recommend that supervision is an area for further investigation which may offer a wealth of rich data.

Further research on mitigating strategies, I feel, would also be a valuable addition to the counselling field. This could create an awareness in counsellors that there are other creative ways of caring for themselves. This may also identify if some mitigating strategies are more helpful than others. This may be important, for example, in the case of disconnection from the client as a strategy, since it may actually be detrimental to the therapeutic relationship.

Finally, during the interview process, one participant disclosed that they had had a client who had been a perpetrator of sexual abuse. This led me to consider what, if any, the differences may be as to the level of vicarious trauma experienced, when dealing with a perpetrator rather than a survivor of abuse. I would, therefore, further recommend that investigating the effects of vicarious trauma on counsellors counselling perpetrators of abuse, may also be of value.

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# Research

## Participants Required.

**Research Title: A Qualitative Investigation into Mitigating the Impact of Vicarious Trauma on Counsellors Dealing with Traumatic Client Material.**

At present I am undertaking a research study as part of a Masters degree at the University of Chester. My area of interest is the effect of vicarious trauma on counsellors working with clients' traumatic material. I am particularly interested in counsellors who feel that their beliefs, values and/or world view has been affected or changed during their counselling practice as a result of working with client's trauma material.

I am looking for qualified counsellors with a minimum of two years post qualification, who have experience in counselling clients with traumatic material. Participants will attend individual interviews lasting approximately 30 to 60 minutes.

If you are interested in participating in this research study and would like more information, please contact:

Pam Collins

Email

## **Appendix 2.**

### **Information for Research Participants.**

Pearlman and Saakvitne (1995) state that “Vicarious traumatization is a process through which the therapist’s inner experience is negatively transformed through empathic engagement with clients’ trauma material”. They argue, that as a result of this, the counsellor’s frame of reference is disrupted and may impact on their identity, world view and/or spirituality.

At present I am a GP counsellor, a counsellor for Mind and a counsellor in private practice. As part of my MA in Counselling studies at University of Chester, I am undertaking a research study into mitigating the effects of vicarious traumatisation in counsellors working with traumatic client material.

Participants will be required to complete a mini questionnaire to ascertain that they meet the selection criteria for this research study and have appropriate support. Having been selected they will then be invited to attend an interview lasting 30 to 60 minutes in duration at a mutually agreed venue. This interview will be audio taped and then transcribed. A copy of both will be available to the research participant.

I would like to reassure all participants that all information will be held in the strictest confidence. Whilst this research will eventually be available in the public domain, all identifying material, including names will be removed. I alone will transcribe the tapes; however, they will be available to those involved in assessing this dissertation. I abide by the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy (2004). Security will be a priority and meet the BACP ethical guidelines.

All participants may withdraw from this research study at anytime up until the submission deadline. Participants will be provided with an opt out form explaining the procedure, and may do so without redress. Upon withdrawal participants will be provided with the original tape, any copies and any transcription up to that point.

Thank you for your interest,  
Pam Collins.

### **Appendix 3.**

## **Participant Selection Questionnaire.**

The purpose of this questionnaire is to ensure that applicants meet the necessary requirements to enable them to participate in this research study. This research study requires six participants. If more than six applications are received, then six will be randomly selected. If a potential participant, therefore, is not successful it is not a rejection of themselves.

Filling in this form does not commit the applicant to having to complete this research study. All information provided in this questionnaire will be treated as confidential.

Name:

Address:

Telephone number:

Email address:

**Participant Information:**

What is the highest counselling qualification you hold?

How long have you been qualified?

Are you in current counselling practice?

Do you have monthly clinical supervision?

Are you a member of the BACP or other?

Do you have BACP accreditation or similar?

What is your theoretical orientation?

Do you have access to a personal therapist?

Are you willing to see them if matters arise due to participant in this research study?

Have you experienced traumatic client material during your counselling career?

Since starting your counselling practice have you noticed that your beliefs, values and/or world view have changed?

Do you have any specific requirements with reference to being interviewed that I need to take into consideration, i.e. room, access, environment etc.?

#### **Appendix 4.**

### **Consent form for research title: A qualitative investigation into mitigating the impact of vicarious trauma on counsellors dealing with traumatic client material.**

I confirm that I have been informed that the information that I will give to Pamela Collins in the audio taped interview will be anonymous and that any identifying material will be removed. I understand that my interview tape and any transcript will be kept confidential in accordance with the BACP ethical guidelines. The only other people to have access to the tape will be those involved in assessment of this dissertation. I will be offered a copy of the tape and transcript when ready.

I am aware that this research will be entering the public domain via the University of Chester library, the internet and may be published in the future.

I understand I have the right to stop the interview at any time and do not have to continue if I so choose. I may then have my audio tape returned to me. I may withdraw from this research study at any time up until the final submission date and I have been supplied with a withdrawal form.

I acknowledge it is my responsibility to arrange to see a personal therapist if I feel that this research has evoked uncomfortable personal material during or after the interview.

I have had the opportunity to explore any questions that I have had in relation to this research study and I am confident that I have received sufficient information to make an informed decision to be a participant.

I..... therefore consent to the given information being used in this research.

Signed (participant) ..... Date.....  
Print Name.....

Signed (researcher) ..... Date.....  
Print Name.....



**Appendix 5.**

**Withdrawal form for research title: : A qualitative investigation into mitigating the impact of vicarious trauma on counsellors dealing with traumatic client material.**

I would like to withdraw from the above research study.

*Please delete as necessary:*

- I would like the master audio tape of my session, all copies and any transcribed material destroyed.
- I would like the master audio tape of my session, copies and any transcribed material returned to me.
- I would/ would not like to be contacted to discuss my withdrawal.

It is possible to withdraw at any time up until the submission date .....

## **Appendix 6.**

### **Interview Questions.**

1. If you look back to when you started your counsellor training, what can you remember about your “self, world view and/or spirituality?”
2. How do you feel this may have changed since then?
3. When did you notice this change in your frame of reference?
4. Thinking back to what your counselling clients have disclosed to you, what traumatic material has impacted on you the most, personally and professionally?
5. How would you describe the effect of this in regards to you personally and professionally?
6. What did you do, if anything, to counteract any negative effects on you?
7. How do you feel when you listen to your client’s traumatic material, physically, emotionally and spiritually?
8. How do you deal with those feelings, if at all?
9. I am interested in knowing what strategies, if any; you have put in to limit the effect of this?
10. If any, how effective do you feel they have they been?
11. What if anything, that you may have tried, has not been effective?
12. Is there anything you have not done that you feel may help mitigate the effects of what you hear and experience?
13. Having discussed this topic today is there anything that has come into your awareness or thoughts about the future?
14. In retrospect is there anything that we have not spoken about that you would like to add?

Thank you for participating in this research study.

## **Appendix 7.**

### **Initial Categories.**

1. How I was pre-counselling.
2. Theoretical orientation.
3. Why I went into counselling.
4. Counsellor training.
5. Beliefs.
6. Self has changed.
7. Change in world view.
8. Ways that have changed my world view.
9. Pre-history.
10. Recent changes.
11. Changes over time.
12. Volume of traumatic material.
13. Severity of case material.
14. Impact caused by.
15. Graphic material.
16. Trust.
17. Withdraw from society.
18. Positive outcome.
19. Recurring over time.
20. Changes emotionally, physically.
21. Impact on personal relationships.
22. Self care.
23. Supervision.
24. Mitigating effects of vicarious trauma.

25. Perceptions of others.
26. Feelings.
27. How much mitigating vicarious trauma.
28. Behaviour.
29. How effective in mitigating vicarious trauma.
30. Does not mitigate vicarious trauma.
31. May mitigate vicarious trauma.
32. Not doing what want to do.
33. Not everything impacts.
34. Spirituality.
35. How I am perceived.
36. Practice.
37. Holding client traumatic material.
38. Empathic engagement.
39. World view.

## **Appendix 8.**

### **Revised Categories.**

1. Pre-counselling frame of reference.
2. Change in frame of reference.
3. Traumatic material.
4. The impact of trauma material.
5. Trust
6. Impact on clients.
7. Positive outcomes.
8. The effects traumatic material has on counsellors.
9. Supervision and mitigation.
10. Mitigating the effects of vicarious trauma.
11. May mitigate vicarious trauma.
12. Does not mitigate vicarious trauma.
13. Participant could do more to mitigate.
14. Participants symptoms of vicarious trauma.
15. Self-care.
16. Growth as a result of traumatic client material.
17. Supervision works.
18. Supervision does not work.
19. Spiritual renewal.

## **Appendix 9.**

### **Propositional Statements.**

1. Participants remember a different frame of reference prior to working with traumatic client material.
2. Participants experienced a change in their frame of reference as a result of working with traumatic client material.
3. Participants were aware that clients' traumatic material had had a significant impact on themselves.
4. Participants experiences of how traumatic client material has impacted on them.
5. Participants recognised the need for self-care when working with traumatic client material.
6. All participants indicated that they used strategies to mitigate vicarious trauma.
7. Participants found their own natural way to mitigate the effect of vicarious trauma.
8. Successful outcomes with clients made the counselling process worthwhile for the participants and, therefore, helped to mitigate vicarious trauma.
9. Participants showed post traumatic growth after dealing with traumatic client material.
10. Participants found talking a useful strategy for mitigating the effects of vicarious trauma.
11. Participants felt that supervision should work towards mitigating vicarious trauma, however, it fell short of their expectations.
12. Participants found barriers in using clinical supervision to mitigate the effects of vicarious trauma.
13. Not all mitigating strategies worked for each individual participant.
14. Participants felt they could do more to mitigate the effects of vicarious trauma than they were doing at the time of the interview.

## **Appendix 10.**

### **Literature Search Results.**

A general search on University of Chester electronic data bases was undertaken in November 2009. Further searches were undertaken between May and July, with one further search in September 2010 to source any recent editions to this research.

November 2009:

I searched entering the key words “vicarious trauma” sourced 737 matches. A further search entering the key words “vicarious trauma” plus “therapist” sourced 2153 matches.

Electronic journal;

Child and Adolescent Mental Health 2009 issue 3,2,1 nothing on vicarious trauma.

Child and Adolescent Mental Health 2010 issue 4,3,2,1 nothing on vicarious trauma.

Electronic data bases;

PsyARTICLES, was searched entering key words “vicarious traumatisation” this yielded 8 results, 5 of these produced relevant research articles. I searched again entering key words “vicarious trauma” this identified 2 results, 1 research article was relevant. A further search using “vicarious traumatization” received 8 results, however, no more new research articles appeared.

Psychology and Behavioural Journal was searched by entering “vicarious traumatisation” this delivered 27 results of which 9 were of use. I searched using key words “vicarious trauma” this yielded 7 results, however, with no new papers. I further searched “vicarious traumatization” and found 14 results, of which 5 were new and of use.

May to September 2010:

During May I gained a deeper understanding of search protocols. This enabled me to extend my search criteria between May and July, with a final search in September.

Extra search terms were added to: “vicarious trauma”, “vt”, “vicarious traumatisation”, “vicarious traumatization”. These were “counsellor”, “counselor”, “therapist”. All these combinations of (English and American) words were also used with the terms “impact”, “mitigating”, “limiting”, “reducing”, “empathic”, “empathic engagement”, supervisor, supervision, trauma supervision and trauma therapy supervision.

These extended searches produced an extra 43 articles that were relevant to this research study, out of 498.

## **Appendix 11.**

### **Data analysis process.**

I used as a basis for the data analysis process the “constant comparative method” as outlined by Maykut and Morehouse (1994, Ch. 9). I have made some adaptation to the process and have been explicit where this is.

I listened to the audio recording of each participant fully before transcribing so that I could hear the narrative in its entirety. I then transcribed the audio tapes onto computer ascribing each participant with a separate file and participant code so that they retained anonymity. During this time I kept a discovery sheet on each participant.

Once transcribed I printed the transcripts off onto different coloured paper. This allowed me to identify each participant more easily. I read the transcript through briefly and then went through them more thoroughly. I added any new discoveries/thoughts to the individual discovery sheets looking for any emergent themes coming out of the transcripts.

At this point I began to unitize the data. Rather than use the big paper process outlined in Maykut and Morehouse (1994) I decided to use the more up to date medium of computer files. I reviewed the discovery sheets and then began to work through each transcript identifying units of meaning. Rather than paper and card I began to put these units of meaning into their own file with a title which most captured the essence of each phrase. I identified each unit of meaning by the colour of paper the transcript was printed on, participant code and page number (the reason for the colour coding is that I am a visual person and it is easier for me to identify quickly). These files formed my first initial categories. This set up a process of diminishing returns and as I went through each further transcript the less new categories began to emerge. This process used the look alike, feel alike criteria outline in Maykut and Morehouse (1994).

Once this was completed I again immersed myself in the data and the provisional categories that had emerged. There were 39 in total. I began to look to see if these categories were relevant to the research and whether they stood alone or could be amalgamated with others. I also began to look for related themes. This process led to the production of 19 revised categories.

The next stage was to write the rules for inclusion for these categories. Rules for inclusion are the statements that outline the parameters of what fits each particular category. 14 propositional statements emerged from this process and have been disseminated in chapter 3. This was an arduous and time consuming process with units of data moving at times from category to category before the propositional statements emerged.